are of enormous potential consequence, given the prevalence of ischaemic heart disease and hypercholesterolaemia in Britain alone. Many hundreds of thousands of patients could require cholesterol lowering drugs once dietary advice has failed. Given the magnitude of the problem, do we need more evidence that such results can be generalised before we embark on this colossal task?

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1 Oliver M, Poole-Wilson M, Shepherd J, Tikkanen M. Lower patients' cholesterol now. *BMJ* 1995;310:1280-1. (20 May.)

2 Ferner RE, Neill HAW. A suitable case for treatment. *Lancet* 1995;345:1051.

Occupational health: undefined, under reported, and uncompensated

Definitions of disease categories are important

EDITOR,—D Sen and K Osborne highlight the fact that occupational disease is underreported and possibly underdiagnosed by general practitioners.¹ They fail, however, to try to rectify the situation by giving the correct definitions of notifiable, prescribed, and reportable diseases. It would be advantageous if articles criticising doctors for lack of knowledge of important definitions included these definitions. Brief definitions are as follows.²

Notifiable infectious diseases (under the Public Health Act 1984) must be reported by the doctor to the local authority. Examples include acute meningitis, infected jaundice, measles, tetanus, and tuberculosis. A full list is given by Kloss.²

Prescribed diseases are specific diseases related to work that are prescribed for particular occupations by the secretary of state in regulations. Sufferers can claim benefit. An example of a prescribed occupational disease is carcinoma of the lung, with evidence of asbestosis, when the sufferer has worked in a specific occupation with asbestos. Another example is vibration white finger when the person has worked in a specific occupation using handheld power drills or other specified equipment.

Reportable diseases are those diseases related to work that must be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations,³ which are currently being updated.⁴ It is the employer's duty to report these diseases if he or she has received a written diagnosis on an employee from a doctor—for example, a medical certificate. Reporting the disease does not necessarily mean that it was caused by work and does not allow the person to claim any benefit. Two examples of reportable diseases are decompression sickness and leptospirosis.

There are 28 reportable diseases and 39 prescribed diseases. Not all reportable diseases are prescribed, and most, but not all, prescribed diseases are reportable. Consequently the two lists of reportable and prescribed diseases overlap considerably, and for patients to gain any benefit from the state they must prove that they worked in a specific occupation that resulted in their disease.

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1 Sen D, Osborne K. General practitioners' knowledge of notifiable, reportable, and prescribed diseases. *BMJ* 1995;310:1299. (20 May.)

2 Kloss D. *Occupational health law*. Oxford: Blackwell Scientific, 1989.

3 *Reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR)*. London: HMSO, 1985.

4 Health and Safety Commission. *Draft proposals for the reporting of injuries, diseases and dangerous occurrences regulations 1990-1994*. Sudbury, Suffolk: HSE Books, 1994.

Occupational health pilot study finds unmet need

EDITOR,—We endorse Anthony Seaton's suggestions regarding occupational medicine,¹ but the current staffing and structure of the NHS occupational health departments seem unlikely to be able to meet the demands of their surrounding communities. What is to happen in the interim?

Our pilot occupational health project found that 61 (13%) of 474 patients interviewed in general practice surgeries were visiting their general practitioner because of health problems related to work; this is higher than the national findings (7%) reported by the Health and Safety Executive.^{2,3} Altogether 191 of the patients interviewed reported ill health resulting from their current or previous jobs, and 400 of the patients reported their lack of access to an occupational health service.

Providing only an outpatient referral service for local doctors as a measure to improve the mechanisms for managing ill health related to work will be inadequate. Programmes to increase awareness among general practitioners are needed, as highlighted by D Sen and K Osborne.⁴ Such programmes would not only enable doctors to identify cases that require referral but also prevent possible conflicts that could arise between general practitioners and occupational physicians.⁵

Given the current emphasis on diagnosis and treatment in the community and primary care settings, occupational health services based in primary care should be supported and developed. At present such services exist as occupational health projects and are mostly funded by the local family health services and district health authorities. There are two in London, four in Yorkshire, one in Liverpool, and one planned for Scotland. They raise awareness of occupational health issues among primary care staff and their patients through interviewing patients and eliciting occupational histories, which become part of the patients' medical records. They also provide interactive feedback with case studies at practice meetings, information, seminars, and advice and support issues such as benefits. In view of the promising evaluations of these projects, making advice on occupational health standard practice in primary care settings should be considered seriously.

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1 Seaton A. Diagnosing and managing occupational disease. *BMJ* 1995;310:1282. (20 May.)

2 Isanedihi RO. *An occupational health project in the east—a report*. London: East London and the City Health Authority, 1994.

3 Health and Safety Executive. *Your patients and their work. An introduction to occupational health for family doctors*. Sudbury, Suffolk: HSE Books, 1992.

4 Sen D, Osborne K. General practitioners' knowledge of notifiable, reportable, and prescribed diseases. *BMJ* 1995;310:1299. (20 May.)

5 Gratton JCD. Effective occupational health—difficulties of delivery. *Occup Med* 1995;45:61-2.

Prescribed diseases yield substantial compensation

EDITOR,—S C Stenton and colleagues suggest that medical practitioners underrefer patients with occupational asthma,¹ while D Sen and K Osborne have gathered evidence highlighting general

practitioners' lack of knowledge about prescribed diseases.² Both papers mention briefly that people diagnosed as having a prescribed disease are eligible to claim disability benefit.

The disability benefit awarded to such people can be substantial, especially if they are also awarded a linked benefit, reduced earnings allowance. This is particularly so with diseases such as asthma, byssinosis, and asbestosis, which can often be diagnosed only on the basis of a detailed work history taken several years after the onset of the disease. Three of my own recent cases serve as examples: a client deemed to have had byssinosis for the past 30 years obtained £15 000 in arrears of disablement benefit and a continuing award of nearly £30 a week; a client diagnosed as having had asbestosis for 20 years was awarded £16 000 in arrears of benefits and £60 a week; and a client with dermatitis was awarded £3000 in arrears and £20 a week.

Many people like these retire early on grounds of ill health, are in poor health, and exist on state benefits. Disability benefit can help them to spend their retirement more comfortably. For some, however, the route to being awarded disability benefit is not easy. The three clients referred to above were successful only after taking their cases to a medical appeal tribunal, which overturned the Department of Social Security's initial decision that they did not suffer from any of the prescribed diseases.

Increased awareness of prescribed diseases should increase the uptake of disability benefit. It should also result in more successes at the point of claim so that fewer claimants are faced with what for many is a lengthy and daunting appeal procedure. Once a diagnosis has been made, people then require sound advice on benefits, particularly when large awards are at stake. Some citizens advice bureaux have developed links with their local general practitioners. In Rochdale we hold regular advice sessions at three local practices and I have had several productive referrals from local general practitioners. While closer liaison between the Benefits Agency and other medical services might be one approach,² having and using a high profile advice agency on the doorstep might also be useful.

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1 Stenton SC, Sandhu PS, Hendrick DJ. Industrial injury benefit for occupational asthma in north east of England. *BMJ* 1995;310:1299-300. (20 May.)

2 Sen D, Osborne K. General practitioners' knowledge of notifiable, reportable, and prescribed diseases. *BMJ* 1995;310:1299. (20 May.)

Incidence of toxoplasma retinochoroiditis

EDITOR,—R E Gilbert and colleagues offered a new insight into the incidence of toxoplasma retinochoroiditis, but raised some doubts.¹ The fascination is that the results are different from previous reports,² which has implications for the management of toxoplasma infection in pregnancy.

The study methods should be carefully examined. Ophthalmologists were required to notify cases of toxoplasma retinochoroiditis to the researchers. Ophthalmologists are busy people and the help of none was acknowledged, so the study's results depended on the altruism of the participants. Three of the nine units reported no cases, which is a bit surprising, but the distribution of patients does seem to reflect a geographical sphere of influence of the researchers. There can be great inaccuracies with voluntary reporting. In Scotland toxoplasmosis is a notifiable disease through a

system in which the clinician notifies the disease and is paid for so doing. Yet during 1992-4 only 19 of the 127 cases (15%) identified by this reference laboratory had been notified; in addition one of the 19 cases (5%) has been falsely notified. The study of Gilbert and colleagues may similarly present substantial underreporting.

Over the years we have not made a special effort to identify cases of ocular toxoplasmosis in Scotland. Yet, on analysing our records of the past three years, we found an incidence for Scotland of 0.35/100 000/year. This is initially the same figure that was reported by Gilbert and colleagues. Our figures are based on positive serological results in patients with clinically confirmed toxoplasma retinochoroiditis. As we are confident many cases will be diagnosed on clinical evidence alone, we believe that our figure represents the minimum incidence and that the real incidence is substantially higher. Significantly, our data for Northern Ireland over the same period show an incidence of 0.63/100 000/year. Antibody prevalence studies in people under 40 indicate a higher rate of exposure to toxoplasma in Northern Ireland³ than in Scotland,⁴ which may reflect the difference in incidence of ocular infection.

Although the study by Gilbert and colleagues is interesting, we believe that the way forward is a proper prospective pilot antenatal screening programme⁵ as this will provide answers that all can accept.

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- 1 Gilbert RE, Stanford MR, Jackson H, Holliman RE, Sanders MD. Incidence of acute symptomatic toxoplasma retinochoroiditis in south London according to country of birth. *BMJ* 1995;310:1037-40. (22 April.)
- 2 Ho-Yen DO. Clinical features. In: Ho-Yen DO, Joss AWL, eds. *Human toxoplasmosis*. Oxford: Oxford University Press, 1992: 56-78.
- 3 Smyth ETM. The epidemiology of *Toxoplasma gondii* infection in Northern Ireland [MD thesis]. Belfast: Queen's University of Belfast, 1993.
- 4 Joss AWL, Skinner LJ, Chatterton JMW, Chisholm SM, Williams HD, Ho-Yen DO. Simultaneous serological screening for congenital cytomegalovirus and toxoplasma infection. *Public Health* 1988;102:409-17.
- 5 Ho-Yen DO, Joss AWL, Chatterton JMW. Congenital toxoplasmosis and TORCH. *Lancet* 1990;335:622-3.

Informed consent to postmarketing research

Patients may feel pressured to participate

EDITOR,—The issue of payment in postmarketing research causes major problems for research ethics committees.¹ Various guidelines give conflicting advice about assessing the financial implications of payment to investigators for research studies of any form, but an additional problem in postmarketing surveillance is that many studies are not submitted to research ethics committees in the first instance. A particular difficulty is that payments to investigators may provide financial inducement for them to enter patients into studies. Many authorities are critical of per capita payments, but, realistically, this is the only way that many pharmaceutical companies can administer their clinical trials. Use of strict inclusion and exclusion criteria, together with a limit on the number of potential patients who can be recruited in any one institution, solves some of this problem. In hospitals it is reasonable for ethics committees to insist that income from pharmaceutical studies is paid into some form of trust fund. If the investigator has to spend considerable time on the study or incurs considerable expenses then he or she can apply to the

trust fund for payment based on national guidelines (currently up to £115.50 an hour). Our committee routinely insists on this, but such advice is not quite so straightforward in general practice, where much postmarketing surveillance takes place.

The published debate implies that patients would not be happy about doctors receiving a fee for enrolling them in studies.¹ An opposing viewpoint is not discussed—namely, that patients would feel under duress to take part as they would be helping their doctor by attracting finances into the practice or department. If payments to researchers are to be explained to patients then it would probably be reasonable to include in the explanation a breakdown of how the finances will be allocated (for example, payments to laboratories, other use of facilities, allocation to the investigator directly or to a research fund, etc).

The fee currently recommended in Britain for postmarketing surveillance studies—£8 per form (or £15 if the form is particularly complex)—is reasonably similar to the median of \$15 suggested by patients in the United States, and very different from the median of \$100 suggested by their doctors.¹ Financial inducement to complete postmarketing surveillance questionnaires may therefore be a lesser issue in Britain than the United States, and a reasonable compromise in financial disclosure might be for patients in this type of study to be informed that their doctor is receiving payment at a nationally agreed rate.

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- 1 La Puma J, Stocking CB, Rhoades WD, Darling CM, Ferner RE, Neuberger J, et al. Financial ties as part of informed consent to postmarketing research. *BMJ* 1995;310:1660-1. (24 June.)

British rules outlaw disguised promotion of drugs

EDITOR,—The articles debating financial ties as part of informed consent to postmarketing research¹ omit to mention that, in Britain, any person querying whether a postmarketing surveillance study is a marketing exercise masquerading as a scientific project should refer it to the Prescription Medicines Code of Practice Authority at 12 Whitehall, London SW1A 2DY, for review. The code of practice for the pharmaceutical industry specifically states that postmarketing surveillance studies must not be disguised promotion, and appropriate action will be taken against any pharmaceutical company that breaches this section of the code.

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- 1 La Puma J, Stocking CB, Rhoades WD, Darling CM, Ferner RE, Neuberger J, et al. Financial ties as part of informed consent to postmarketing research. *BMJ* 1995;310:1660-3. (24 June.)

Coping with a diagnosis of breast cancer

EDITOR,—I read Ann McPherson's article with a great sense of empathy.¹ Six months ago I too was diagnosed as having breast cancer, and her description of the "investigation process" and the emotions she felt at the time brought back vivid memories. I am pleased that her diagnosis was handled with understanding and sympathy. For me it was very different—something it still hurts to talk about—and I now see the relevance of the

increased emphasis that is placed on communication skills in the undergraduate curriculum. It is a shame that some of the more distinguished consultants are not invited to attend these seminars.

The first weeks after my diagnosis it was as if life had overtaken me in the fast lane. There was a holiday to cancel, clinics to attend, recurrent seromas to be drained, readmission to hospital, Christmas to prepare for, and then radiotherapy in the new year. I was in the middle of a PhD investigating the methodology of randomised controlled trials, and my husband said that developing a carcinoma so that I could participate in a trial was beyond the call of duty.

I agree with McPherson that little information is available to women about how they are likely to feel during and after treatment. I was grateful to be able to get such information from a doctor whom I had met the week before my diagnosis. Even so, I did not think that the tiredness, crying, poor body image, low self esteem, or inability to think straight would affect me and tried to carry on as if everything was all right. It is only now that the physical difficulty of going to radiotherapy as well as to work, the supermarket, and the gym has passed that I have realised that behind my smile I am crying inside. Although many trials in the past have concentrated on survival rates, the more recently established trials include an assessment of quality of life as one of their outcome measures, so perhaps more information will become available for future generations of women.

One of the hardest things to do was to tell my parents, and I still feel unable to talk to them of the possibility that I may die before them. Six months ago, if anyone had asked me how old I would be when I died I would have replied "probably in my 80s" because that's how old my grandparents were when they died. Now, though, at the age of 34, I feel that I probably won't live to that age and I may die considerably sooner. This uncertainty has made me reassess my life and, to quote an advertisement, "Live life to the MAX."

Since my diagnosis I have realised that there is a need for women to be educated about the importance of entering randomised controlled trials. I believe that if women were made aware of such issues before their disease was diagnosed then the decision to enter a trial would be easier to make. I would like to draw readers' attention to an article by Baum.² He proposes that healthy women interested in improving the treatment of cancer should be educated about the need for clinical trials so that those who go on to develop cancer will not have to face the difficult problem of understanding clinical trials as well as the new knowledge of their diagnosis.

I hope that, through all our efforts, women faced with the diagnosis of breast cancer will be told their diagnosis sympathetically, treated with respect, and have as much information as they want about their disease and its treatment made available to them.

- 1 McPherson A. The quality of the b(r)east. *BMJ* 1995;310:1339. (20 May.)
- 2 Baum M. New approach for recruitment into randomised controlled trials. *Lancet* 1993;341:812-3.

Corrections

Monitoring during endoscopy

Owing to a typesetting error the name of the second author of the first letter in this cluster (12 August, p 452) was spelt incorrectly. The author's correct name is Raymond J Delicata.

Measuring NHS activity

An editorial error occurred in this letter by John Charlton and Karen Dunnell (12 August, pp 454-5). In the key to the figure the labels for the lines "consulted general practitioner" and "attended as outpatient" were transposed.